X. Record Management

A. Local Policy and Standing Orders

Each health department must have local policies and standing orders approved, signed, and annually updated by the health director, PHN administrator, TB nurse, and the local TB physician/medical consultant.

B. Clinical Records

1. Each health department must have a clinical record system that provides medical and legal documentation of services rendered including a recall system for required follow-up.

2. Records must be clear, concise, and descriptive of the course of care for the patient. Documentation should include counseling, services rendered that are not documented elsewhere, services rendered on behalf of the patient, and follow-up attempted and/or completed.

3. Agency policy must define the types and location of various components of the complete record system.

4. The following forms may be downloaded from the TB Control website https://epi.dph.ncdhhs.gov/cd/tb/lhds.html#forms to be utilized as the department deems appropriate in their overall patient record system:

   a. Tuberculosis Register Card (DHHS 2245)
   https://epi.dph.ncdhhs.gov/cd/tb/docs/dhhs_2245.pdf
   - May be used if health department finds it useful.
   - Provides an overview of patient status and services rendered.
   - Serves as a "tickler" or recall system for required follow-up.
   - Initiated on persons currently receiving services and placed in the register.
   - Filed in the clinical record upon termination of services or placed in a separate section of the register pending nurse consultant review.

   b. Tuberculosis Drug Record (DHHS 1391)
   https://epi.dph.ncdhhs.gov/cd/tb/docs/dhhs_1391.pdf
   - Serves as a medical, legal record of drugs supplied.
   - Provides uniform record for all patients receiving TB drugs.
   - Initiated on all persons started on drugs and placed in the chart or a loose-leaf notebook in alphabetical order.
   - Reviewed at least weekly to recall patients due for refills.
   - Filed in the clinical record upon termination of drug therapy.

   c. Tuberculosis Flow Sheet (DHHS 2810)
   https://epi.dph.ncdhhs.gov/cd/tb/docs/dhhs_2810.pdf
   - Provides documentation of monitoring for adverse drug reactions **prior to providing refills.**
   - Placed in the clinical record upon termination of drug therapy.

d. Tuberculosis Epidemiological Record (DHHS 1030)
https://epi.dph.ncdhhs.gov/cd/tb/docs/dhhs_1030.pdf
- Provides TB-related medical and epidemiological history.
- Provides documentation of chest x-ray reading and medical orders.
- Provides documentation of patient education and consent/refusal for services.

e. Record of TB Contacts (DHHS 1662)
https://epi.dph.ncdhhs.gov/cd/tb/docs/dhhs_1662.pdf
- Provides a summary of contacts identified and evaluated.
- Initiated for each TB suspect/case that has contacts identified.
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f. Individual Contact Form (DHHS 4097)
https://epi.dph.ncdhhs.gov/cd/tb/docs/dhhs_4097.pdf

- Provides a summary of an individual contact
- May be used to collect information about an individual contact

g. Record of Tuberculosis Screening (DHHS 3405)
https://epi.dph.ncdhhs.gov/cd/tb/docs/dhhs_3405.pdf
- Provides a record of the individual's tuberculosis status.
- Provides a record of annual verbal screening for employment/residency requirements.

C. Obtaining Records from Other Providers

G. S. 130A-144 (b) requires physicians and persons in charge of medical facilities or clinical or pathology laboratories to permit the State Health Director and local health directors to obtain a copy of medical records pertaining to communicable diseases or conditions.

A written release signed by the patient is advised in all situations where possible, but is **not** legally required within North Carolina.

1. Substance Abuse Facilities:

a. Provide written release signed by the patient; or
b. Initiate a signed agreement between the substance abuse facility and the local health department for sharing of communicable disease patient information.

2. VA Hospitals require VA 10-5345 for records release.

3. N.C. Department of Corrections:

a. Request records/status reports of current inmates from the nurse at the inmate's prison unit.
b. Request records of released inmates from:

Medical Records Manager, DOP Health Services

2405 Alwin Ct, Raleigh, N.C. 27699-4268
Telephone: (919) 715-1570 or 919-715-1584
Fax: 919-715-1581

4. Sanitoria Records:

Patient records and x-rays from N.C. sanatoria are no longer available.

D. Transferring Records

1. No release is required to transfer records between health departments in North Carolina.

2. Interstate Transfer of Records:

a. Obtain a signed release from the patient if possible (**not required** for transferring information necessary for patient follow-up).
b. Call TB nurse in receiving jurisdiction.
c. Prepare a summary (TST, x-ray, drug record, HIV status, M. tuberculosis cultures and susceptibilities).
d. Forward information to receiving jurisdiction; the Interjurisdictional TB Notification Form can be downloaded from the NTCA web site at http://www.tbcontrollers.org/resources/interjurisdictional-transfers/#.V46YCqKUJ-8

E. Record Retention

The following is paraphrased from the Records Retention and Disposition Schedule, Local Health Departments, September 7, 2007, page 89, item 10, including recent amendments, published by the Division of Archives and History: https://files.nc.gov/dncr-archives/documents/files/Health_Department_2019.pdf

1. TB infection; no TB disease (TST positive; chest x-ray negative for TB)
   a. **Retain** for the life of the individual:
      - Last x-ray interpretation;
      - TB Drug Record, if treated; and
      - HIV test results, if tested.
   b. **Destroy** x-ray films 10 years after the last date of any health department services.

2. TB disease (treated as a clinical or laboratory confirmed TB case):
   a. **Retain** for the life of the individual:
      - Last **x-ray film and** interpretation;
      - TB Drug Record(s);
      - Last M. tuberculosis culture result with susceptibilities;
      - HIV test results, if tested;
      - Summary of treatment; and
      - Hospital discharge summaries, if any.
   b. **Destroy** all but the most recent x-ray film after 10 years.

3. **Destroy** all records and x-ray films

a. Upon death **if** more than 10 years after the last date of any health department services; or
b. When patient reaches 90 years of age **if** more than 10 years after the last date of any health department services.